V. S. No. 2
50M—5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Harris

State File No. 30547

FILED OCT 8 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 771

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hosp. 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Months (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Willard (If outside city or town limits, write "RURAL") 0
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME: Sarah Frances Earnest
3. (b) If veteran, name war: No
3. (c) Social Security No. No
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: J.H. Earnest
6. (c) Age of husband or wife if alive: Dec. years
7. Birth date of deceased: April (Month) 27 (Day) 1861 (Year)
8. AGE: Years 84 Months 5 Days 0 If less than one day hr. min.
9. Birthplace: Marionville (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation: Home
11. Industry or business:
FATHER 12. Name: John Stakely
13. Birthplace: UNK. (City, town, or county) Tennessee (State or foreign country) 1
MOTHER 14. Maiden name: Eleanor Haun
15. Birthplace: UNK. (City, town, or county) Tennessee (State or foreign country) 1
16. (a) Informant: Mrs. R.H. Wilson
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Eastlawn
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 10-1-45 (Date received local registrar) (b) D W Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 year 1945 hour 6 minute 30a. M.
21. I hereby certify that I attended the deceased from July 10, 1945, to September 27, 1945 and that I last saw her alive on September 26, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriolonephrosclerosis with uremia	1 wk.
Due to: Generalized arteriosclerosis	20 yr.
Due to:	
Other conditions (Include pregnancy within 3 months of death): Arteriosclerotic heart disease	3 mo.

Major findings: Of operations:
Of autopsy: 97

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Thomas S. Harris M.D.
Address: Medical Arts Bldg. Springfield, Mo. Date signed 10/1/45

(Licensed Embalmer's Statement on Reverse Side)

944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Walter E. Hamilton

Licensed Embalmer No. 3848

P. O. Address Springfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.